STATE OF MICHIGAN

IN THE SUPREME COURT

MICHIGAN CHIROPRACTIC SOCIETY and the MICHIGAN CHIROPRACTIC COUNCIL,

Petitioners-Appellees,

v

FARMERS INSURANCE EXCHANGE and MID-CENTURY INSURANCE COMPANY,

Intervening Respondents-Appellants,

and

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES,

Respondent.

Supreme Court No. 126530, 126531

Court of Appeals Case Nos. 241870, 241874

Related Case No. 241445

Circuit Court File No. 01-93481-AA

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APPELLEES' BRIEF ON APPEAL

ORAL ARGUMENT REQUESTED

THE APPEAL INVOLVES A RULING THAT A PROVISION OF THE CONSTITUTION, A STATUTE, RULE OR REGULATION, OR OTHER STATE GOVERNMENTAL ACTION IS INVALID

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES
(continued)

CONSTITUTION

STATUTES

TABLE OF AUTHORITIES
(continued)

Page

COURT RULES

OTHER AUTHORITY

STATEMENT OF JURISDICTION

Farmers Insurance Exchange and Mid-Century Insurance Company sought leave from the Court of Appeals' decision in *Michigan Chiropractic Council v Commissioner of the Office of Financial and Insurance Service*, 262 Mich App 228; 685 NW2d 428 (2004). This Court granted the application for leave to appeal in an unpublished order entered on May 13, 2005, pursuant to its authority under MCR 7.301(A)(2), which permits review of a case "after decision by the Court of Appeals." The Michigan Chiropractic Society and Michigan Chiropractic Council do not contest the jurisdiction of this Court.

COUNTER-STATEMENT OF QUESTIONS INVOLVED

I. DID THE LOWER COURTS CORRECTLY CONCLUDE THAT THEY MUST APPLY REVIEW DE NOVO TO THE QUESTIONS OF LAW IN THIS CASE TO DETERMINE WHETHER THE COMMISSIONER'S DECISION WAS AUTHORIZED BY LAW?

Commissioner answers: Did not answer.

Trial Court answers: Yes.

Court of Appeals answers: Yes.

Farmers answers: No.

MCC/MCS answers: Yes.

II. DID THE LOWER COURTS CORRECTLY CONCLUDE THAT THE OPTIONAL MANAGED CARE ENDORSEMENT LIKE THAT OFFERED BY THE INTERVENORS VIOLATES THE NO-FAULT ACT, MCL 500.3101 *ET SEQ.*?

Commissioner answers: No.

Trial Court answers: Yes.

Court of Appeals answers: Yes.

Farmers answers: No.

MCC/MCS answers: Yes.

III. DID THE COURT OF APPEALS CORRECTLY CONCLUDE THAT THE ENDORSEMENT IS POTENTIALLY DECEPTIVE AND MISLEADING?

Commissioner answers: Did not answer.

Trial Court answers: Did not answer.

Court of Appeals answers: Yes.

Farmers answers: No.

MCC/MCS answers: Yes.

IV. DO PETITIONERS HAVE STANDING TO BRING THEIR PETITION AND THE REMAINING COUNTS IN IT?

Trial Court answers:	Did not answer.
Court of Appeals answers:	Did not answer.
Farmers answers:	No.
MCC/MCS answers:	Yes.

I. COUNTER-STATEMENT OF FACTS

A. Introduction

This appeal asks whether an insurer can avoid providing the personal injury protection (PIP) coverage mandated in the No-Fault Act, MCL 500.3101 *et seq.*, for "reasonably necessary" expenses incurred for the proper care, recovery or rehabilitation of an injured no-fault insured by subjecting its no-fault insureds to managed care. Farmers Insurance Group[1] seeks to entice insureds to accept lesser coverage under its Preferred Provider Option Endorsement ("PPO Endorsement") by (1) allowing the insurer to determine "the appropriateness of health care services," (2) eliminating the choice of providers by using a closed network of providers, (3) imposing a $500 deductible if the insured seeks care outside the closed network, and (4) reimbursing out-of-network providers at the lower in-network rates. Response by Farmers, Exhibit 2 (App, p 45a). The Michigan Chiropractic Council ("MCC") and Michigan Chiropractic Society ("MCS") represent Michigan chiropractors who care for people injured in automobile accidents and, therefore, rely on their no-fault coverage to obtain care. The PPO Endorsement violates the rights of insureds *and* the rights of providers, including MCC and MCS members, by imposing managed care on no-fault personal injury protection benefits and refusing to reimburse providers for their reasonable and customary fees incurred by insureds for reasonably necessary care.

In 2000, the Commissioner of the Office of Financial and Insurance Service ("Commissioner") was deemed to have approved the PPO Endorsement by failing to act within thirty days of when Farmers submitted the no-fault policy for review under MCL 500.2236. Response by Farmers, p 1, (App, p 15a). The PPO Endorsement created a managed-care system for personal injuries sustained in automobile accidents in return for a reduced premium. *Id.* at p 2 (App, p 16a). Farmers contracted with

[1] "Farmers" refers collectively to Farmers Insurance Exchange and Mid-Century Insurance Co.

the Preferred Provider Organization of Michigan ("PPOM") to establish a preferred provider panel for insureds who select the managed-care policy. *Id.* at ¶2 (App, p 17a). The purpose of the preferred provider panel is to limit the insureds' benefits and choice of providers as cost-savings techniques. *Id.* at p 2 (App. p 16a). As Farmers' disclosure for the PPO Endorsement says, "[T]he insurer and/or its designated health care review agency will manage the care, monitor, and review the appropriateness of health care services which are covered" under the policy. *Id.* at Exhibit 3, ¶ 2 (App, p 45a). The PPO Endorsement is not expressly intended to improve the quality of health care or health outcomes.

Under the PPO Endorsement, Farmers' insureds must pay a $500 deductible for seeking care from providers not on this PPOM panel. Response by Farmers, Exhibit 2 (App, p 45a). This "deductible" is $200 *more* than expressly allowed under MCL 500.3109. Farmers does not contend that the deductible corresponds to the cost incurred for the services provided out-of-network. Rather, this $500 fee – which is more than five times the expected annual savings of $70 to $85 for electing this option – constitutes a penalty against the insured for seeking out-of network care. Petition, Exhibit B (App, p 13a). More importantly, even if the preferred provider panel fails to offer reasonably necessary services for an insured, the insured must be able to afford the $500 fee in order to receive out-of-network care. This managed-care policy also affects all the members of the household of an insured who elects the PPO Endorsement because they are required to have this managed-care policy, too. Response by Farmers, Exhibit 2 (App, p 44a).

Farmers refuses to reimburse out-of-network providers at their reasonable and customary rates when providing reasonably necessary services to insureds with this PPO Endorsement. Instead, Farmers will "reduce[]" the rates charged by the out-of-network provider "to the amount which would have been payable" had the insured "used the services, utilization review and fee schedules of the designated PPO." Response by Farmers, Exhibit 2, ¶c (App, p 44a) and Exhibit 3, ¶5 (App, p 45a). This method

of providing reimbursement for out-of-network services ignores whether the rates actually charged are reasonable and customary. Farmers, thus, cleverly shifts the burden of paying for reasonably necessary services to the insureds who must pay out-of-pocket "for the difference in deductible and cost." *Id.* at Exhibit 3, ¶5 (App, p 45a). In other words, with the managed care PPO Endorsement, Farmers is no longer liable to pay for reasonably necessary services because the insured is required to pay the difference between the in- and out-of-network service rates unless the out-of-network health care providers absorb this difference in reimbursement.

With this reduced reimbursement scheme, Farmers has forced out-of-network providers who care for its insureds with this managed-care policy to become *de facto* members of PPOM's provider panel because they receive the same reimbursement as in-network providers. Alternatively, their insureds become uninsured patients whom out-of-network providers must chase for the portion of their reasonable and customary fees that PPOM will not reimburse. Additionally, there are evidently services that Farmers will not cover *at all* because it has reserved to itself the sole discretion and right to determine whether care is "appropriate," regardless of whether it is reasonably necessary. Response by Farmers, Exhibit 3, ¶2 (App, p 45a). In this instance, there is an exclusion in no-fault coverage for those services which are reasonably necessary but which Farmers deems are not "appropriate".

B. The Petition and Commissioner's Decision

In August 2000, MCC/MCS petitioned the Commissioner for a Notice of Hearing and Commencement of Administrative Proceedings in a three-count complaint under the Insurance Code, MCL 500.2001 *et seq.*, and the Uniform Trade Practices Act, MCL 500.2236. Petition (App, p 3a). By September 2000, Farmers had intervened and, two months later, MCC/MCS amended the petition. Amended Petition (App, p 47a). In the amended petition, MCC/MCCS alleged that they

> are voluntary associations assisting the over 2,000 chiropractors in this State, whose members are involved in chiropractic health care and who are dedicated to promoting and protecting the public health and to establishing and protecting the rights and interests of their members, including the improvement and advancement of the practice of chiropractic in the State of Michigan. [Amended Petition, ¶2 (App, p 48a).]

Additionally:

> The MCS and MCC members provide reasonably necessary medical care to Farmers' insureds and, by virtue of the challenged policy, are excluded by Farmers in violation of the No-Fault Act and unable to obtain reasonable access to no-fault insureds or proper payment for their customary charges. [Amended Petition, ¶3 (App, p 48a).]

MCC/MCS also asserted four claims in the Amended Petition. Counts I and II presented opposite sides of the same issue, arguing that the PPO Endorsement violated the rights of insureds (Count I) and providers (Count II) by creating managed care for PIP benefits. (App, p 49a-53a). Count III asserted that the PPO Endorsement violated MCL 500.3109 by imposing a $500 penalty on insureds for seeking out-of-network services. (App, p 54a). In Count IV, MCC/MCS alleged that, in denying coverage for chiropractic care in favor of care by doctors of osteopathy, Farmers violated MCL 500.2026(n) by failing to provide a reasonable basis for the denial of a claim, violated MCL 500.2026(a) by misrepresenting the coverage offered and related facts, and violated MCL 500.3475 for reimbursing only comparable care. (App, p 54a-57a)

MCC/MCS's position was that the No-Fault Act was intended to create a fee-for-service system of benefits and the managed care imposed by the PPO Endorsement directly contradicted that intent. Amended Petition, ¶15-20, 21 (App, p 48a, 51a-52a). They contended that managed care can only be offered for no-fault policies if and when the Legislature expressly authorizes it. *Id.* at ¶6 (App, p 49a). The Legislature had signaled that this express authorization was necessary by passing 1993 PA 143 to rewrite the No-Fault Act and, among other things, offer managed care; if the absence of an express bar against managed care were enough to permit it to be offered, then 1993 PA 143 would have been

unnecessary. *Id.* at ¶10-13 (App, p 49a-50a). However, the people of Michigan rejected 1993 PA 143, including the managed-care provision, in its entirety at a referendum that year, further emphasizing that it was not acceptable to impose managed care on no-fault insurance. *Id.* at ¶14-15 (App, p 50a-51a). MCC/MCS asked the Commissioner to investigate Farmers, institute a contested-case hearing and withdraw approval of the PPO Endorsement. *Id.* at p 10 (App, p 57a).

In response to Counts I and II, Farmers took the position that, though not expressly authorized, the PPO Endorsement was lawful because it was not inconsistent with the No-Fault Act and 1993 PA 143 was irrelevant to this issue. Response to Petition, ¶10-14 (App, p 20a-23a). Farmers conceded that its obligation to provide coverage was fixed in MCL 500.3107, but said

> that its obligation to insureds is, as a matter of Michigan law, set forth in MCL §500.3107. This standard may not be, and is not, contractually altered by the Option or any other insurance policy or provision. Insureds receive no different scope or quality of medical care under the Option than they would receive outside the PPOM network. The Option merely defines the universe of providers from whom insureds may obtain medical treatment without having to pay a deductible and fee differential." [*Id.* at ¶21 (App, p 26a-27a).]

As for Count III, Farmers contended that the PPO Endorsement did not impose an unlawful penalty in the form of the $500 deductible. *Id.* at ¶27 (App, p 29a). As Farmers saw it, it was entitled to this deductible because it is paid in exchange for a 40% reduction in the premium and allowed by MCL 500.3109, and insureds can avoid any hardship the $500 imposes by staying in the network. *Id.* at ¶28 (App, p 30a).

On January 23, 2001, the Commissioner issued an order denying the petition in part. Order, 1/23/01 (App, p 63a). The Commissioner recognized that, of the four claims, only Count IV involved questions of fact regarding a specific denial of no-fault benefits; Counts I, II, and III each presented

questions of law regarding the meaning of the No-Fault Act and its application to the PPO Endorsement. *Id.* at p 4-5 (App, p 66a-67a). The Commissioner framed the parties' dispute, stating:

> *The essential facts are not contested.* Respondent's Preferred Provider Option allows policyholders to elect to limit their choice of medical care providers in the event they suffer auto related injuries. Policyholders who elect the Preferred Provider Option receive a 40% reduction in the premium for personal injury protection coverage. If they are injured in an automobile accident, policyholders who elect the option must either get their treatment from a network of medical care providers maintained by Preferred Providers of Michigan (PPOM), or, if they go outside the network, they must pay a $500 deductible and reimbursement is limited to the amount the network pays for the service. Policyholders are not required to select the Preferred Provider Option. They may preserve a broader choice of medical care providers by declining the option and foregoing the premium reduction. [*Id.* at p 5 (App, p 67a) (emphasis added).]

The Commissioner rejected the claim in Count I that the PPO Endorsement violated the rights of insureds, holding that it was not "inherently inconsistent" with Farmers' statutory duty under MCL 500.3107 to cover reasonable charges incurred for reasonably necessary products, services, and accommodations because Farmers claimed it could provide this care within the PPOM network. Order, 1/23/01, p 6-7 (App, p 68a-69a). Further, the history of 1993 PA 143 was irrelevant to whether offering managed care was inconsistent with the No-Fault Act. *Id.* at p 8-9 (App, p 70a-71a). As for Count II, the Commissioner concluded that the PPO Endorsement did not violate the rights of providers because insureds choose their providers by electing their policy, providers voluntarily participate in PPOM, and providers do not have a right to be chosen to render care. *Id.* at p 10-11 (App, p 72a-73a). The Commissioner also concluded that insureds were not penalized by the $500 deductible because it accounted for increased costs associated with going out-of-network, which insureds could avoid by staying in-network. *Id.* at p 15 (App, p 77a). Still, the Commissioner noted that it would be unlawful for Farmers to inflate the cost of its standard policy in order to force insureds to accept the reduced premium offered by the PPO Endorsement. *Id.* Implicit is that a scheme that is not truly voluntary violates the No-Fault Act. The Commissioner issued a separate order on March 21, 2001, dismissing

Count IV without prejudice because the same comparable-care issue was pending in the Court of Appeals in *Sprague v Farmers Insurance Exchange*, 251 Mich App 260; 650 NW2d 374 (2002). Count IV is not at issue in this appeal.

C. The Circuit Court's Decision

MCC/MCS filed a petition in the circuit court seeking review of the Commissioner's decision regarding the claims that the PPO Endorsement violated the rights of insureds and providers by imposing managed care and that Farmers had also violated the No-Fault Act, MCL 500.3109, by requiring comparable care instead of chiropractic. Review Petition (App, p 83a). MCC/MCS contended that because the PPO Endorsement was not permitted by law, the Commissioner had acted outside his authority by approving it and that the decision was arbitrary. *Id.* at p 7-13 (App, p 89a-95a). MCC/MCS argued that the Commissioner had: failed to understand the legal significance of the referendum on 1993 PA 143 in rejecting managed care for no-fault policies; ignored the provisions of the No-Fault Act that preclude managed care and the reimbursement cap imposed on out-of-network providers; and had used a double standard when requiring MCC/MCS to come forward with evidence to support purely legal claims when the evidence could only be obtained if the Commissioner commenced an investigation and when the Commissioner accepted unsupported assertions from Farmers. *Id.* MCC/MCS asked the circuit court to reverse the Commissioner's decision and stay the approval of the PPO Endorsement. Farmers continued to assert the same arguments it had made before the Commissioner regarding the PPO Endorsement.

The circuit court concluded that the PPO Endorsement "illegally adds an additional requirement that health care providers must be members of Farmers' exclusive Preferred Provider Network." Circuit Court Opinion and Order, 4/30/02, p 6 (App, p 140a). The circuit court also concluded that forcing providers to accept in-network reimbursement rates conflicted with the requirement that "providers be

reimbursed when providing treatment for a covered injury" and that they be reimbursed their "customary and reasonable fee." *Id.* The circuit court agreed with MCC/MCS's arguments concerning the structure and purpose of the No-Fault Act in creating a fee-for-service system of care for individuals injured in automobile accidents. *Id.* at p 6-7 (App, p 140a-141a). In the circuit court's view, "[T]he authority to bring managed care to the no-fault system is a matter which the Legislature must determine." *Id.* Therefore, the circuit court concluded that the Commissioner had committed error requiring reversal because the PPO Endorsement was not authorized by law. *Id.* at p 7 (App, p 141a).

On May 22, 2002, the circuit court issued an order clarifying its earlier decision. Circuit Court Opinion and Order, 5/22/02 (App, p 146a-148a). This order reversed the Commissioner's decision regarding the effect of the PPO Endorsement on the rights of insureds and providers. *Id.* This order also concluded that the Count IV issue regarding comparable care was moot in light of the Court of Appeals' decision in *Sprague*, *supra*, which was favorable to MCC/MCS's position. *Id.*

D. The Court Of Appeals' Decision

Farmers appealed the circuit court's decision to the Court of Appeals, narrowing the substantive issues to whether the PPO Endorsement violated the rights of insureds and providers by creating managed care with a reimbursement cap. After MCC/MCS filed its brief and had no chance to comment, Farmers raised for the first time the argument that MCC and MCS lacked standing to challenge the PPO Endorsement because some of their chiropractors were members of PPOM. In support, Farmers expanded the record on appeal by submitting an affidavit from Lynne Wharton, the Director of Provider Network Operations at PPOM. Wharton Affidavit, ¶1 (App, p 207a). Wharton stated that, between 1998 and 2002, PPOM had a verbal agreement for an exclusive contract with Michigan Chiro/Net Corporation ("MC/NC") to provider the chiropractors for its provider panels. *Id.* at ¶3 (App, p 207a). Since then, however, Wharton contended that any chiropractor meeting the credential

requirements of PPOM could become a PPOM preferred provider and that more than 1,200 chiropractors had done so, including members of the MCC/MCS. *Id.* at ¶3-4 (App, p 207a). According to Farmers, this chiropractor participation in PPOM meant that the members of MCC and MCS benefited from the PPOM system and, therefore, could not challenge it.

MCC/MCS, with leave of the Court, countered this standing argument with an affidavit from Kristine L. Dowell, the Executive Director of the MCS. Court of Appeal Order, 3/28/03 (App, p 15b); Dowell Affidavit, ¶1 (App, p 8b and 29b). Dowell explained that when the Commissioner approved the PPO Endorsement, and while the petition in this case was pending before the Commissioner *and* the lower court, only chiropractors who were members of the MCS could belong to the MC/NC. Dowell Affidabit, ¶3 (App, p 8b and 29b). Because of the exclusive arrangement between PPOM and MC/NC, only MCS chiropractors could join the provider panel and MCC members were excluded. *Id.* Further, when MC/NC first began its association with PPOM, Farmers did not offer a managed care no-fault policy. *Id.* at ¶4 (App, p 8b and 29b). The MCS chiropractors who participated on PPOM preferred provider panels were not caring for Farmers' insureds under the PPO Endorsement; rather, they were providing managed care to insured under other health-care policies. *Id.* In light of this affidavit, MCC/MCS argued, there was no question that they had standing to challenge the PPO Endorsement. Petitioner's Responsive Brief, p 3-4 (App, p 21b-22b).

The Court of Appeals, with Judge Neff authoring the lead opinion in which Judge Fitzgerald concurred, issued its opinion in June 2004 affirming the circuit court. The Court of Appeals framed the issue on appeal as whether the PPO Endorsement "violates Michigan's no-fault insurance statute" by offering insureds "a reduction in their personal injury protection (PIP) premium in exchange for agreeing to obtain medical treatment exclusively from providers in Farmers' PPO network." *Michigan Chiropractic Council v Commissioner of the Office of Financial and Insurance Service*, 262 Mich App

228, 232; 685 NW2d 428 (2004) ("*MCC*"). Though acknowledging that its review was limited to whether the Commissioner's decision was "authorized by law," the Court of Appeals nevertheless recognized that the issue in this case was purely legal and, therefore, required review *de novo*. *Id.* at 233. In other words, the Court of Appeals understood that it had to determine whether the law permitted Farmers to offer the PPO Endorsement, a task that required review *de novo*. Only by answering that purely legal question could the Court of Appeals determine whether the Commissioner's decision was authorized by law.

The Court of Appeals began its analysis by providing an overview of the Commissioner's statutory authority to review and approve insurance policies, as well as the No-Fault Act's function as a "comprehensive scheme of compensation designed to provide sure and speedy recovery of certain economic losses resulting from motor vehicle accidents." *MCC*, *supra* at 233-236. Though the No-Fault Act did not expressly permit or prohibit managed care, the Court of Appeals concluded that it included a number of provisions relevant to whether the PPO Endorsement's managed-care system for no-fault benefits was lawful. *Id.* at 237.

Read together, the Court of Appeals explained, MCL 500.3105 and MCL 500.3107 require no-fault insurers to pay for the reasonable expenses an insured incurs for reasonably necessary care as the result of an automobile accident resulting in bodily injury. *Id.* at 237-238. MCL 500.3157 adds that those who provide care to no-fault insureds who have sustained bodily injury stemming from an automobile accident are entitled to be reimbursed for their reasonable and customary charges. *Id.* at 238-239. Further, MCL 500.3109a permits insurers to reduce premiums in exchange for coordinating a no-fault policy with other health care benefits, but does not permit a reduction in benefits required by MCL 500.3107. *Id.* at 244. In fact, even where the No-Fault Act provides for the set-off or coordination of no-fault benefits with other health benefits, the no-fault benefits required under MCL 500.3107 are

still mandated when the primary policy does not provide for them. *Id.* at 243-244. In this way, the No-Fault Act maintains the balance the whole scheme strikes between "wide ranging medical benefits from the available spectrum of providers" and "the statutorily prescribed, limited redress for personal injuries suffered." *Id.* at 245. The managed-care system imposed by the PPO Endorsement, however, was antithetical to the "range of choice" MCL 500.3107 and the No-Fault Act as a whole were intended to provide. *Id.* at 243. The penalties for insureds seeking out-of-network services were further evidence that the PPO Endorsement was contrary to the No-Fault Act, the Court concluded. *Id.* at 245-246.

The Court of Appeals also offered an alternative ground for affirming the circuit court and reversing the Commissioner's decision. *MCC*, *supra* at 239. In a separate, self-contained section of the *MCC* opinion labeled IV(A), the Court of Appeals examined the relationship between the 40% reduction in premium that Farmers advertised for the PPO Endorsement and the other credits or premium reductions allowed by the No-Fault Act. *Id.* at 239-240. For instance, the Court noted, an insured can elect to reduce the premium by 15% in exchange for accepting a $300 deductible and a seven-day waiting period for work loss benefits under the E7143 reduction. *Id.* at 240. Or, an insured can reduce the premium by 35% by making the no-fault benefits secondary to other policies. *Id.* Not only are some of these reductions comparable to the savings offered by the PPO Endorsement, they are not available if an insured selects the PPO Endorsement, which requires a larger deductible and eliminates a choice of coverage for other household members. *Id.* As a result, the Court concluded, "This system certainly has the potential for deception--misleading consumers and the public in general. This potential deception provides *further basis* for reversing the commissioner's decision pursuant to MCL 500.2029, on the basis of unfair, deceptive, and misleading trade practices." *Id.* at 241 (emphasis added).

The Court of Appeals did not address the other issues the parties raised. Rather, the Court held, "Farmers' system of PPO-limited medical benefits inherently conflicts with Michigan's no-fault act.

Because the PPO endorsement at issue is inconsistent with the act, the commissioner was obligated to withdraw approval of the policy form incorporating the endorsement, pursuant to MCL 500.2236. The circuit court's reversal of the commissioner's decision was therefore not error." *Id.* at 246.

Judge White, who drafted her own concurring opinion, joined in this holding that offering managed care violated the No-Fault Act. *Id.* at 247. She did not join in the alternative grounds for affirming the circuit court identified in Section IV(A) of the opinion, which related to the deceptive or misleading nature of the 40% premium reduction for the PPO Endorsement. *Id.* Judge White also highlighted what she saw as two additional flaws in Farmers' arguments. First, Farmers argued that the PPO Endorsement did not reduce the benefits it was required to cover under MCL 500.3107 if the insured stayed in-network for those services. *Id.* at 247-248. However, Judge White said, "[W]hile the endorsement may provide the required coverage if the insured goes to a managed-care provider, it clearly does not provide the required coverage if the insured does not go to such a provider." *Id.* at 248. Instead, the insured must pay a $500 deductible and the provider must accept less than its reasonable and customary charge as reimbursement. *Id.* Judge White found this to violate the No-Fault Act. *Id.* Second, Farmers argued that it accommodated the choice of providers inherent in the No-Fault Act by allowing its insureds to choose to accept the limited choice of PPOM providers when contracting for the PPO Endorsement and, therefore, its penalties for seeking services out-of-network were permissible. *Id.* Yet, Judge White concluded, "if the insured chooses to seek reasonable services for a reasonable charge from a provider that is not part of the managed-care network, and the insurer does not pay that charge, the no-fault statute has been violated." *Id.*

Finally, Judge White noted that the No-Fault Act lacked the careful regulation that applies to the managed-care industry. *Id.* at 249. Because Farmers' no-fault insureds do not become PPOM participants by choosing the PPO Endorsement, Farmers' no-fault insureds with the PPO Endorsement

lack the protection regulations afford to other insureds who have managed care for their health care policy. *Id.* Farmers has a contractual arrangement with PPOM; however, the only contract the insured has is with Farmers. Yet, the insured's benefits are affected by the arrangement between farmers and PPOM.

II. THE LOWER COURTS CORRECTLY CONCLUDED THAT THEY MUST APPLY REVIEW DE NOVO TO THE QUESTIONS OF LAW IN THIS CASE TO DETERMINE WHETHER THE COMMISSIONER'S DECISION WAS AUTHORIZED BY LAW

As the Court of Appeals noted and Farmers agrees, an agency decision that does not stem from an evidentiary hearing is reviewed to determine whether the action was "authorized by law." See *MCC*, *supra* at 232, citing *Northwestern National Casualty Co v Commissioner of Insurance*, 231 Mich App 483, 487-491 (1998). This reference to whether the agency decision was "authorized by law" comes from the text of Const 1963, art 6, §28, which states in relevant part:

> All final decisions, findings, rulings and orders of any administrative officer or agency existing under the constitution or by law, which are judicial or quasi-judicial and affect private rights or licenses, shall be subject to direct review by the courts as provided by law. This review shall include, *as a minimum, the determination whether such final decisions*, findings, rulings and orders *are authorized by law*; and, in cases in which a hearing is required, whether the same are supported by competent, material and substantial evidence on the whole record. . . . [Emphasis added.]

The effect of §28, which is located in the article concerning the Judiciary, is simply to allow courts to engage in direct review of decisions by agencies outside the Judiciary and to prescribe the *minimum* inquiry in each case depending on whether the decision required a hearing. Nothing in §28 bars courts from engaging in a more searching review of legal questions decided without a hearing, much less requires deference to agency decisions made without a hearing where the question involves the construction of a statute.

A standard of review describes the deference an appellate court must grant to a lower court, tribunal, or agency decision. See, *e.g.*, *People v Babcock*, 469 Mich 247, 666 NW2d 231 (2003)

(describing standard of review in terms of whether deference is given to trial court). Understandably, the courts have reserved to themselves the right to decide questions of law like the interpretation of statutes and insurance policies without any deference to lower bodies, *i.e.*, *de novo* review. See *City of Grosse Pointe Park v Michigan Municipal Liability and Property Pool*, 473 Mich 188; __ NW2d __ (2005), slip op at 10 ("[T]he proper interpretation and application of an insurance policy is a question of law that we review *de novo*."); *Lincoln v General Motors Corp*, 461 Mich 483, 489-490; 607 NW2d 73 (2000) ("Issues concerning the interpretation and application of statutes are questions of law for this Court to decide *de novo*."). This *de novo* standard of review for questions of law flows directly from the constitutional power of the courts. As Const 1963, art 6, §1 states, the "judicial power" is "vested exclusively" in the courts. This core judicial power under §1 is to interpret and apply the law. See *School District of the City of Pontiac v City of Pontiac*, 262 Mich 338, 353; 247 NW 474 (1933) ("The constitutional duty of courts is to interpret and apply the law . . . ."); see also *Koontz v Ameritech Services, Inc*, 466 Mich 304, 312; 645 NW2d 34 (2002) ("[T]he proper role of the judiciary is to interpret and not write the law . . . .").

It would be wholly illogical to read §28 as a limit on the power of the Judiciary to interpret and apply the law in cases in which they have appellate jurisdiction, such as this case. Section 28 does not authorize agencies to make any type of decisions, much less provide binding interpretations of the law. Quite the contrary, §28 limits agency power to act without subsequent judicial review. At the same time §28 expands judicial power by subjecting agency decisions to direct judicial review. *De novo* review is the embodiment of this judicial power to review agency interpretations to ensure that they are a correct construction and application of the law. This Court cannot and should not abdicate its constitutional role in deciding the law in favor of deferring to agency interpretations because no other governmental body, not even the Legislature, is authorized to fill the void that would create. The Court should also question

why it should defer to an agency decision that the Commissioner does not continue to defend. Presumably, the Commissioner is satisfied with the Court of Appeals' decision because it did not appeal.

Further, although applying different analyses, this Court has consistently reached this ultimate conclusion that courts – not agencies – must be the final arbiters of questions of law and, therefore, there are limits to judicial deference to agency determinations concerning legal questions. In *Consumers Power Co v Public Service Com'n*, 460 Mich 148, 157 n 8; 596 NW2d 126 (1999), this Court made clear that it does not defer to an agency interpretation of a statute when the meaning of the statute is plain. Similarly, in *Western Michigan University Bd. of Control v State*, 455 Mich 531, 565 NW2d 828 (1997), this Court stated that, "while an agency's construction generally deserves deference, it is not controlling," in rejecting an agency's "limited and artificial definition" of a statute. See also *State Treasurer v Abbott*, 468 Mich 143, 660 NW2d 714 (2003) (Supreme Court defers to federal agency interpretation of statute only if it is based on "permissible construction"). Nor does this Court defer to an agency if its interpretation is inconsistent "with the purpose and policies of the statute itself." *Empire Iron Mining Partnership v Orhanen*, 455 Mich 410, 416; 565 NW2d 844 (1997).

The practical result of this philosophy of deferring to an agency interpretation of a statute – but only when the agency has interpreted the statute correctly – for the "authorized by law" standard was explained in *Northwestern*, *supra* at 488. In *Northwestern*, the Court of Appeals held that "it seems clear that an agency's decision that is in violation of statute [or constitution], in excess of the statutory authority or jurisdiction of the agency, made upon unlawful procedures resulting in material prejudice, or is arbitrary and capricious is a decision that is not authorized by law." (Alteration in original and internal quotation marks omitted.) This formulation in *Northwestern* essentially separates the "authorized by law" review into two separate analyses. First, the courts must determine what the law means, which requires *de novo* review of the law itself. This first step would be unnecessary only if the

courts have already settled the interpretation of the law. Second, the courts must compare the agency decision with the judicial interpretation of the law in order to determine whether the decision was authorized by law. This step would give some deference to the agency only to the extent that the law might authorize a range of agency decisions depending on the facts, thereby affording the agency some discretion in choosing its course of action or decision. If there is only one correct course of action or decision by the law, such as here, then the agency would have no discretion to depart from that legal standard.

This two-part analysis is precisely the format used in *Brandon School Dist v Michigan Ed Special Services Ass'n*, 191 Mich App 257; 477 NW2d 138 (1991), a case adopted in *Northwestern* and on which Farmers relies in this case. In *Brandon*, the Court of Appeals first independently determined the meaning of MCL 500.2043 and MCL 550.950, concluding that they offered discretion to the Commissioner to hold a contested-case hearing when probable cause exists. *Id.* at 265. This was a *de novo* review of the statutes. As a second step, the Court determined whether the Commissioner had acted within the scope of this statutory discretion when determining not to hold a hearing. *Id.*

As it plays out in this case, this relationship between the *de novo* standard of review and the "authorized by law" standard in §28 means that the Court must first determine *de novo* the substantive legal question whether the No-Fault Act permits a managed-care policy. There is no factual dispute regarding the terms of the PPO endorsement and that it imposed managed care. Order, 1/23/01, p 5 (App, p 67a). Both the PPO Endorsement and Farmers' disclosure explicitly describe this as "managed care." Response by Farmers, Exhibits 2 and 3 (App, p 44a-45b). Consequently, only if the No-Fault Act would permit a managed-care policy with all of the PPO Endorsement's attributes would the Commissioner have any discretion to deny the contested-case hearing and permit Farmers to offer this PPO Endorsement to its insureds. This is precisely the process that both the circuit court and Court of

Appeals followed. Therefore, their decision to use the *de novo* standard of review for this first step of the analysis was correct, not error requiring reversal.

In any event, even if the Court interprets the appropriate standard of review differently, it would have no effect on the substantive resolution of whether the Commissioner erred by allowing Farmers to offer the PPO Endorsement. Under the established precedent, any deference that would be granted to the Commissioner's decision is inappropriate if MCC/MCS are correct that the PPO Endorsement violates the No-Fault Act. See *Empire Iron*, *supra* at 416. In that case, MCL 500.2236 requires the PPO Endorsement to be withdrawn, making the Commissioner's approval erroneous.

III. THE LOWER COURTS CORRECTLY CONCLUDED THAT THE MANAGED-CARE ENDORSEMENT LIKE THAT OFFERED BY THE INTERVENORS VIOLATES THE NO-FAULT ACT, MCL 500.3101 *ET SEQ.*

A. By Adopting A Fee-for-Service System, The No-Fault Act Inherently Bars Managed Care, Which *Tousignant* Confirms

Farmers contends that the absence of an express bar against managed care in the No-Fault Act makes managed care permissible. However, in this instance, the Legislature did not need to enact an express provision for the No-Fault Act to bar managed care. Under the rules of statutory construction, "[e]xpress mention in a statute of one thing implies the exclusion of other similar things." *Sebewaing Industries, Inc v Village of Sebewaing* 337 Mich 530, 545; 60 NW2d 444 (1953). In this instance, the No-Fault Act expressly employs a fee-for-service, *i.e.*, indemnity, system of insurance, thereby excluding other forms of insurance, like managed care. Sections 3105, 3107, 3109a, 3112, and 3157 of the No-Fault Act work in conjunction to create the essential components of a fee-for-service system of insurance for accidental bodily injuries arising from motor vehicle accidents. These essential components are:

> (1) the right of a no-fault insured to seek reasonably necessary "products, services, and accommodations" for "care, recovery, or rehabilitation" without any limitation on the

type of bodily injuries eligible for coverage or the providers from whom the insured can seek products, services, and accommodations, MCL 500.3107;

(2) the right of the provider to charge a reasonable (not to exceed) a customary amount for giving those products, services, and accommodations to the insured, MCL 500.3157;

(3) an assurance equally important to the insured and provider that the insurer assumes the risk of financial loss because it "is liable to pay" those reasonable and customary amounts for reasonably necessary products, services, and accommodations, MCL 500.3105;

(4) an acknowledgment that providers and insureds have a mutual and legitimate interest in the reimbursement of services and therefore PIP benefits "are payable to or for the benefit of an injured person," MCL 500.3112; and

(5) a limitation on the right of the insurer to offer deductibles and exclusions, such as coordination of benefits, in exchange for a reduced premium to those situations where the insured is guaranteed full mandated benefits required under the No-Fault Act, MCL 500.3109a.

As one authority confirms, "[I]n enacting the Michigan no-fault automobile insurance law in 1973, the Michigan Legislature did not draft a statute that utilizes managed-care concepts, as did other states that adopted a no-fault scheme. On the contrary, the Michigan no-fault law is purely a fee-for-services plan." George T. Sinas, "Case Management and the Michigan No-Fault Law: A Look at the Legal Issues," 79 Mich Bar J 1348 (Oct 2000).

In *Cruz v State Farm Mut Automobile Ins Co*, 466 Mich 588, 598; 648 NW2d 591 (2002), this Court also established that, when confronted with a question regarding insurer conduct that the No-Fault Act does not address directly, its obligation is to determine whether the conduct is consistent with the "no-fault regime" as a whole. A policy clause that excuses or minimizes an insurer's full compliance with the essential provisions of the No-Fault Act is, by its very nature, in conflict with the no-fault regime "and, therefore, invalid." *Id.* at 601; see *id.* at 598, 600.

Under *Cruz*, *supra*, managed care in any of its many forms and the PPO Endorsement are directly incompatible with the no-fault regime and, therefore, are invalid. The essence of a fee-for-

service system of insurance is that, in return for paying a premium, insureds are permitted to seek care from *providers of their choice* and the insurer is obligated to pay the charges for those services. See, generally, Russell Korobkin, *The Efficiency Of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, And Market Failure*, 85 Cornell L Rev 1, 10 (Nov 1999) (describing the fee-for-service system). In contrast, managed care eliminates an insured's choice of the providers from whom they can seek care, imposes limits (capitation) on provider reimbursement, may deny coverage altogether or prescribe penalties or fees if the insured does not seek care from pre-selected providers, and, in some cases *like the PPO Endorsement*, allows the insurer to make decisions regarding what care is appropriate. See, generally, Allison Faber Walsh, *The Legal Attack On Cost Containment Mechanisms: The Expansion Of Liability For Physicians And Managed Care Organizations*, 31 J Marshall L Rev 207, 215-221 (1997) (discussing cost containment methods of manages care).

The fee-for-service insurance system also imposes the risk of financial loss on the insurer while preserving decisions regarding care for the insured and provider. See, generally, Mary R. Anderlik and Wendy J. Wilkinson, *The Americans With Disabilities Act And Managed Care*, 37 Hous L Rev 1163, 1167-1170 (2000) and Vernellia R. Randall, *Managed Care, Utilization Review, And Financial Risk Shifting: Compensating Patients For Health Care Cost Containment Injuries*, 17 U Puget Sound L Rev 1, 4-6 (1993) (both describing risks allocated under indemnity insurance and managed care). Managed care achieves the opposite, preserving decisions regarding care for the insurer and imposing the risk of financial loss predominantly on the provider by limiting reimbursement, but also on the insured who seeks care when full coverage for a service is not offered. *Id.* Farmers' PPO Endorsement has re-written the required coverage to exclude benefits for those reasonably necessary services that it does not deem "appropriate health care services." It also does not have to pay a reasonable and customary charge to out-of-network providers.

The critical role that choice plays in the no-fault system is not an abstract concept given little effect in reality. For more than fifteen years, this Court has held that the No-Fault Act "preserves to the injured person a choice of medical service providers." *Morgan v Citizens Ins Co of America*, 432 Mich 640, 643; 442 NW2d 626 (1989). Farmers presents the limitation on the choice of providers inherent in managed care generally (and the PPO Endorsement specifically) as a rational tradeoff made in pursuit of savings for the insured and the insurer. However, this Court in *Morgan* understood that choice comes at a cost and, nevertheless, held that the No-Fault Act requires choice over savings. As the Court noted, "The no-fault act preserves to injured persons a reasonable choice of hospitals and physicians although this may add to the premium cost of no-fault insurance. *The no-fault insurer cannot, in the name of reducing the premium cost, require an injured person to obtain medical services from a particular provider.*" *Id.* at 647-648 (emphasis added). Managed care is patently inconsistent with Michigan's no-fault scheme.

Despite this clear authority, Farmers persists in twisting the subsequent holding in *Tousignant v Allstate Insurance Company*, 444 Mich 301; 506 NW2d 844 (1993), to argue that this Court has abandoned the principle of provider choice in the No-Fault Act in favor of cost savings provided by managed care. To the contrary, *Tousignant* confirms that allowing the insured a choice of providers is an indispensable component of the no-fault scheme that cannot be bargained away for the cost savings of managed care.

In *Tousignant*, the plaintiff had a no-fault policy that was coordinated with the managed care health plan her employer offered. *Id.* at 304. This coordination, which is authorized under §3109a, meant that her health plan was her primary insurance and her no-fault policy was her secondary insurance. *Id.* Under the language of the policy, the plaintiff's no-fault policy was not liable to pay for benefits mandated under §3107 if those mandated benefits were "paid, payable or required to be

provided" by her employer-offered health plan. *Id.* This coordination was voluntary and a cost savings for the plaintiff. *Id.* at 307. When the plaintiff in *Tousignant* injured her back and neck in an automobile accident, both her health care plan and no-fault plan refused to pay for treatment she obtained from out-of-network providers. *Id.* at 305.

The Supreme Court held that, because the plaintiff's no-fault and employer-offered health policies were voluntarily coordinated as authorized in §3109a, the no-fault insurer was not obligated to pay for services the health plan would offer or cover. *Id.* In reaching this decision, the Court noted that §3109a "does not require a health insurer to provide particular benefits," referring to the employer-offered health plan, *not* the no-fault policy. *Id.* at 312. Nevertheless, in the Court's view, it was critically important that the plaintiff did not challenge the availability or quality of the care her health plan offered or reimbursed. *Id.* at 312-313. The Court clearly contemplated that, if reasonably necessary care were not available from or covered by the health plan, then the plaintiff would be entitled to fallback on the coverage offered by her no-fault policy in order to obtain the care the No-Fault Act entitled her to receive. *Id.* at 313. By coordinating her benefits, the plaintiff did not give up any of her rights to reasonably necessary care under §3107 and her no-fault policy, which is the right that provider choice protects. Instead, plaintiff failed to follow the dictates of her health plan which otherwise would have provided benefits.

Farmers' core argument that *Tousignant* approves managed-care benefits stems from a fundamental misunderstanding of the relationship between a health plan and a no-fault insurer when benefits are coordinated. In Farmers' view, when a health plan is paying for or providing care for injuries an insured sustains in an automobile accident, then the health plan has become the *de facto* no-fault insurer. Therefore, Farmers contends, the Court's conclusion in *Tousignant* that the plaintiff's health plan was not required to offer choice to the insured excuses no-fault insurers from offering

choice. See *Tousignant, supra* at 310 (discussing the effect of §3109a for "other health coverage," meaning benefits payable by someone other than the no-fault insurer). Farmers blurs the distinction the *Tousignant* Court drew between the employer-offered health plan, which may be managed care, and the no-fault policy. This Court has specifically rejected the argument that medical benefits paid by an entity other than a no-fault insurer can be considered PIP benefits under the No-Fault Act. See *Auto Club Ins Ass'n v New York Life Ins Co*, 440 Mich 126, 138-139; 485 NW2d 695 (1992) ("Even though, as a result of coordination, the obligation of NY Life [the medical group insurer] to provide benefits became primary, it does not follow that NY Life was transformed into a no-fault insurer any more than it follows that the benefits due under its policy were transformed into no-fault benefits."). At no place in *Tousignant* or in any other opinion has this Court held that a *no-fault policy* can use managed care.

Permitting managed-care no-fault policies has other implications for the no-fault scheme that the Legislature did not intend. The Legislature is aware of the rising tide of health care costs. However, the Legislature chose coordination of benefits under §3109a as the appropriate response to that public policy issue. Under §3109a, an insured is allowed, but not required, to designate his or her health plan benefits as primary and no-fault as secondary. Approximately 90% of Michigan's no-fault market is coordinated. This means that services for catastrophic injuries that are otherwise reimbursed through the Michigan Catastrophic Claims Association and result in assessments against Michigan drivers under MCL 500.3104 are paid through the coordinated insured's existing health care plan; because of coordination, no-fault policies do not pay for most catastrophic claims. If, as Farmers claims, its *primary* PPO Endorsement results in the greatest reduction in premium offered, even more than its coordinated coverage, it is to be expected that insureds will purchase more primary no-fault policies. The Legislature's choice to allow the allocation of costs for catastrophic claims (and, frankly, most losses) to health care plans under §3109a will be jeopardized and the PPO Endorsement will directly

compete with legislative policy. No-fault policy costs will once again soar as more insureds choose primary no-fault coverage.

Farmers claims that this shift back to primary no-fault policies is warranted because some insureds do not have a secondary health care policy to coordinate with a no-fault policy. As a result, Farmers says, these insureds cannot take advantage of the premium discounts available for coordinated benefits under §3109a. In Farmers' view, forcing more costs back into the no-fault system contrary to the legislative purpose embodied in §3109a is warranted so that this group of insureds without a health care plan can obtain a premium discount. The Legislature presumably determined, however, that most Michigan citizens, fortunately, have health care coverage for which they already pay in one fashion or another. To reverse this policy is a legislative decision. Section 3109a expressly requires insurers to offer insureds the option of placing the principal burden of automobile-related health care costs on their health coverage. Believing everything that Farmers and the *amici* supporting its position advance in favor of the PPO Endorsement leads inexorably to the conclusion that they believe the Legislature's judgment embodied in §3109a is unsound. This is why it is a legislative matter. Primary managed-care no-fault collides head on with §3109a's attempt to foster coordinated policies. *Cruz, supra,* instructs that it must be disallowed.

In sum, because the lack of provider choice, reallocation of financial risk inherent in managed care, and the effect of making no-fault policies primary are directly contrary to the scheme the Legislature chose for no-fault benefits, the Legislature plainly barred managed care. There is no dispute in this case that Farmers' PPO Endorsement is a form of managed care that limits the choice of providers and, especially with respect to out-of-network providers, reallocates the financial risk of loss for providing services to an insured to the provider by capping reimbursement at the in-network rate. The PPO Endorsement utterly fails to act as the safety net for gaps in coverage that might exist under

other health plans for bodily injuries resulting from motor vehicle accidents, which *Tousignant* highlighted as an important purpose of no-fault insurance. Managed care and this PPO Endorsement directly threaten the right of insureds to reasonably necessary care under §3107 and therefore both must be declared invalid as a direct conflict with the fee-for-service system the Legislature created in the No-Fault Act. In all events, this particular Endorsement violates the No-Fault Act.

B. Managed Care Under The PPO Endorsement Would Render §§ 3107 and 3157 Meaningless

This Court has emphasized time and time again that "[t]he fundamental rule of statutory construction is to give effect to the Legislature's intent. Courts are bound to give effect to all the words in a statute." See *Nowell v Titan Ins Co*, 466 Mich 478, 482; 648 NW2d 157 (2002). In this case, however, Farmers' argument that the No-Fault Act permits managed care and therefore permits it to offer the PPO Endorsement would render several provisions of the No-Fault Act meaningless. This type of conflict with the No-Fault Act makes the PPO Endorsement "invalid." *Cruz*, *supra* 660.

1. Section 3107

Section 3107 guarantees coverage for "*reasonably necessary* products, services, and accommodations for an injured person's care, recovery, or rehabilitation." Emphasis added. This is a subjective standard, taking into consideration what is "reasonably necessary" to each individual insured for care, recovery, and rehabilitation. Managed care, however, offers only the products, services, and accommodations in the amount, for the length of time, and by the provider the insurer chooses in the policy. If insurers were allowed to offer managed care for their no-fault PIP benefits, they would eviscerate this concern for the insured's care, recovery, and rehabilitation expressed in §3107. Contrary to this statutory requirement of coverage for "reasonably necessary" care, Farmers' PPO Endorsement offers only what it determines in its exclusive discretion to be "appropriate" care. Response by Farmers,

Exhibit 3 (App, p 45a). The definition of a covered Rehabilitation Expense in the PPO Endorsement also fails to meet the statutory standard of reasonably necessary expenses. Response by Farmers, Exhibit 2 (App, p 44a). Rather, the PPO Endorsement covered only "reasonable *and* necessary" expenses. *Id.* (emphasis added).

The Legislature has, in a number of different statutes, also defined certain types of care and access to certain providers as part of reasonably necessary care. For instance, under MCL 550.53(6), an insurer may not discriminate against classes of providers in order to allow insureds access to their services. Farmers claims that its in-network providers render all reasonably necessary care, but there is no way to verify that it actually offers this care. Count IV of this case, which was resolved by *Sprague*, actually involved Farmers' failure to provide access to chiropractors. Because the Commissioner refused to institute a contested-case hearing, there is no evidence that Farmers actually offers access to these and other providers. Further, even if Farmers included all the various classes of provider in its closed network, an insured may not be able to obtain reasonably necessary care from a PPOM preferred provider depending on any number of factors, such as: the type of injury; when the injury occurs; whether the insured is traveling a distance from home when he or she sustains an injury and the availability of in-network providers in that area; whether PPOM contracts with an adequate number of specialists; and whether the reduced reimbursement PPOM offers discourages providers with skill and experience from joining the network. Allowing managed care under this PPO Endorsement and other no-fault policies will emasculate the substantive requirements of the No-Fault Act. All of the foregoing access/quality questions are self-regulated in the fee-for-service no-fault system. PPOM has all the control under the PPO Endorsement; but, the insured has not contracted with PPOM.

2. Section 3157

Section 3157 establishes the basis for provider reimbursement, allowing them to collect "reasonable" amounts that are not in excess of their "customary" charges, stating:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a *reasonable amount* for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution *customarily charges* for like products, services and accommodations in cases not involving insurance.

Farmers would have this Court accept as a matter of fact that as long as it convinces its in-network providers to accept a reimbursement rate, no matter how low, that rate is reasonable and therefore complies with §3157 when paid to out-of-network providers. However, the reasonableness of a fee depends on a variety of factors. See, generally, *Michigan Tax Management Services Co v City of Warren*, 437 Mich 506, 509-510; 473 NW2d 263 (1991) (discussing factors relevant to reasonableness of attorney fees, such as the experience of the professional, the effort involved in rendering services, the difficulty of the problem addressed, and expenses incurred). Farmers is not entitled to blanket permission to pay providers unreasonably low rates, contrary to the express language in §3157.

Farmers contends that the PPO Endorsement does not violate §3157 because that section does not offer providers the right to be chosen to provide services in order to obtain reimbursement and providers may agree to limit their reimbursement to the in-network rate fee if they desire. However, MCC/MCS do not contend that §3157 gives any individual provider the "right" to reimbursement under the No-Fault Act unless and until he or she actually provides treatment. Rather, MCC/MCS contend that the PPO Endorsement conflicts with §3157 of the No-Fault Act by limiting payments to providers who actually treat insureds under the Act, but who have *not* voluntarily joined the PPOM network. The PPO Endorsement is anything but voluntary for those providers.

Providers do have a right to participate in the no-fault system without being forced to accept something less than their reasonable and customary fee. In *Lakeland Neurocare Centers v State Farm Mutual Automobile Ins Co*, 250 Mich App 35; 645 NW2d 59 (2002), the Court of Appeals held that providers are persons possessing legal rights under the No-Fault Act. The Court noted that pursuant to §3112, PIP benefits are payable both to and "for the benefit of" the insured. *Id.* at 38-40. Providers, therefore, clearly have standing under the Act to protect their rights for rendering services "on behalf of" the insured. If this Court allows managed-care no-fault insurance, a provider will be forced to give up payment of reasonable and customary fees under §3157 to participate at all. That would be a drastic revision of the plain requirements of §3157. It also restricts access to MCC/MCS members to the no-fault system.

C. Making Managed Care A "Voluntary" Option For Insureds Does Not Make It Permissible For Mandatory PIP Benefits

Farmers goes to great lengths to suggest that, as long as managed care is offered to insureds as a voluntary option, then it is permissible under the No-Fault Act. However, insureds cannot contract away their rights because "PIP benefits are mandated by statute under the no-fault act, MCL 500.3105; MSA 24.13105, and, therefore, the statute is the 'rule book' for deciding the issues involved in questions regarding awarding those benefits." *Rohlman v Hawkeye-Security Ins Co*, 442 Mich 520, 502 NW2d 310 (1993). The parties to a no-fault insurance policy may only determine the benefits to be provided when they are "not required by the statute." *Id.* at 525; see *Mate v Wolverine Mut Ins Co*, 233 Mich App 14, 19; 592 NW2d 379 (1998) ("*Because* such insurance is not mandated by statute, the scope, coverage, and limitations of underinsurance protection are governed by the insurance contract and the law pertaining to contracts.") (emphasis added). Because the PPO Endorsement concerns mandatory PIP benefits, Farmers cannot rely on the fact that the restrictions on mandated PIP benefits is a valid expression of the freedom to contract. Insureds may no more contract away mandatory benefits than

Bill Gates (if he were a Michigan driver) could forego insurance altogether because he can afford to pay his own medical bills.

In any event, if this Court holds that managed-care PIP benefits are consistent with the No-Fault Act, it will in the same stroke of the pen make the voluntary nature of the PPO Endorsement and other similar policies illusory. If this Court permits managed-care PIP benefits at all, nothing would prevent Michigan no-fault insurers from dropping their indemnity policies, like the fee-for-service standard no-fault policy that Farmers offers, to offer only managed care. This would be directly contrary to §3107. The Commissioner noted as much in his decision when he commented that Farmers would violate the law if it contrived to eliminate a standard no-fault policy by making only the PPO Endorsement financially feasible. Order, 1/23/01, p 15 (App, p 77a). Despite this risk to the standard no-fault policy and mandated PIP benefits in general, the Commissioner did not give only conditional approval in order to ensure that it did not lead to the demise of the fee-for-service no-fault system. Instead, the Commissioner ignored this very real risk and approved the PPO Endorsement.

The Legislature has added innovations to the No-Fault act, such as coordinated care under §3109a or benefit off-sets under §3109(1). However, in each instance, the Legislature *enacted* a new provision of the No-Fault Act and did not leave those innovations to be worked out by insurers and the courts. The Legislature may change the essential nature of the no-fault system if it wishes to do so, but it is not up to the courts to make such a sweeping change. See *Koontz*, *supra* at 312.

D. The Repeal of 1993 PA 143 Bars Managed Care Under the No-Fault Act

In this case, the Court of Appeals purported to decline to address whether the history of 1993 PA 143 is relevant to determining that managed care violates the No-Fault Act, but then proceeded, *in dicta*, to reject it. The Court noted that "we reject any argument that the enactment or subsequent repeal by

referendum vote of 1993 PA 143 is determinative in this case. That legislation made comprehensive changes to Michigan's no-fault insurance scheme. Because the referendum rejected the Act in its entirety, it has little bearing on the disposition of this case." *MCC*, *supra* at 246 n 12. The Court completely missed the mark. Proper analysis of this history further supports the Court of Appeals' determination that the PPO Endorsement was improper and the Commissioner should have withdrawn approval for it.

Pursuant to 1993 PA 143, the Legislature enacted a §3104b to the No-Fault Act providing that "[a]n automobile insurer may use clinical care management for each insured whose personal injury protection insurance benefits are not expected to exceed [$300,000]." In the same bill, the Legislature amended §3107 to provide "benefits . . . for. . . [a]llowable expense . . . incurred for *medically appropriate* products, services, and accommodations for an injured person's care, recovery or rehabilitation." Emphasis added. Notably, the Act would have allowed coverage restricted to "appropriate care." The Legislature also enacted §3104a to create a PIP task force to implement a plan regarding cost reduction utilizing "managed care, preferred provider arrangements, case management, treatment protocols, utilization review, rehabilitation, and other contractual agreements." Together, §§ 3104a, 3104b, and 3107 authorized no-fault insurers to implement managed-care and prudent purchaser programs and procedures for no-fault insureds. Had §3107 not been amended to refer to "*medically appropriate* products, services, and accommodation," allowing PIP benefits to be determined on the basis of managed-care protocols would not have been permissible.

These changes completely altered the no-fault scheme that existed then (and now) by eliminating the requirement under §§ 3105, 3107, and 3109 that insurers pay "all reasonable charges incurred for reasonably necessary products, services, and accommodations". These changes empowered the insurer to decide what was "medically appropriate" by adding an additional element requiring that the services,

accommodations, etc., had to be "reasonably likely to provide continued effectiveness" and creating an internal review scheme to deal with disputes arising from these insurer-made determinations. These changes to the No-Fault Act under 1993 PA 143 probably would have authorized the PPO Endorsement offered by Farmers because the statutory language is virtually identical to the language in the PPO Endorsement. However, these managed-care provisions once envisioned by the Legislature are not the law now. The citizens of Michigan rejected 1993 PA 143 in a referendum vote pursuant to Const 1963, art 2, § 9.

Both the enactment of 1993 PA 143 and its subsequent rejection are illuminating in this case. The Legislature passed 1993 PA 143 because it knew that the No-Fault Act did not permit managed care. See *Recorder's Court Bar Ass'n v Wayne Circuit Court*, 443 Mich 110, 127; 503 NW2d 885 (1993) ("The Legislature is presumed to know the law in effect at the time of its enactments."). Had the No-Fault Act implicitly permitted managed care because it did not expressly bar it, then it would have been unnecessary to pass these managed-care provisions in 1993 PA 143. See *English v Saginaw County Treasurer*, 81 Mich App 626, 631; 265 NW2d 775 (1978) ("[W]hen the Legislature adopts an amendment to a statute, it is presumed that the Legislature intended to make some change.").

When the citizens of Michigan repealed 1993 PA 143, it *removed the provisions of the No-Fault Act that permitted managed care.* The referendum nullified a law *already passed* by the Legislature and on the books. Public Act 143 wrought several changes, including the ones altering the nature of the PIP benefit delivery system. This is not a situation where it is not clear what the people voted upon. Citizens are presumed to know the requirements of the law, and the same applies to ballot proposals. Citizens are presumed to know the requirements of the law. See *Adams Outdoor Advertising v East Lansing*, 463 Mich. 17, 27 n 7; 614 NW2d 634 (2000). In no context is this more clear than with referenda. As this Court has explained, "[T]he political foundation for initiative and referendum is the

assumption that a free people act rationally in the exercise of their power. . . . 'People are presumed to know what they want, to have understood the proposition submitted to them in all its implications, and by their approval vote to have determined that [the proposition] is for the public good and expresses the free opinion of a sovereign people.'" *In re Proposals D&H*, 417 Mich 409, 423; 339 NW2d 848 (1983). The rejection of 1993 PA 143 *necessarily* rejected managed care, even if there were numerous reasons to reject the entire act.

Both the people and the Legislature have spoken. The No-Fault Act does not permit managed care, especially the PPO Endorsement, until an express provision allowing managed care is enacted. In the absence of such an express provision in the No-Fault Act permitting managed care, Farmers cannot offer the PPO Endorsement and, therefore, the Commissioner's decision not to withdraw approval for it was not "authorized by law."

IV. THE COURT OF APPEALS CORRECTLY CONCLUDED THAT THE PPO ENDORSEMENT IS POTENTIALLY DECEPTIVE AND MISLEADING

Farmers contends that the Court of Appeals erred in concluding that its PPO Endorsement was deceptive and misleading and, therefore, would have been a "further basis" for reversing the Commissioner's decision. According to Farmers, the trade-offs between the three no-fault policies it offers (standard, coordinated, and managed care) are apparent to insureds. However, as the Court of Appeals noted, the no-fault policies Farmers offers does not offer a straight-forward system of premium reductions. *MCC*, *supra* at 239-240.

For instance, Farmers does not offer a standard policy at full price, a coordinated policy with a 15% premium reduction, and a managed-care policy with a 40% premium reduction. Nor does Farmers offer to carryover the premium reduction for coordination to its managed-care policy; in other words, the 15% premium reduction for coordination is *not* added to the 40% reduction for managed care for a total

55% premium reduction for the PPO Endorsement. Instead, Farmers has created a complex system of tradeoffs that the average consumer in the real world is not likely to be able to understand. The 15% premium reduction for coordination is off-set by a $300 deductible and the 40% premium reduction for managed care is off-set by a $500 deductible. Choosing the PPO Endorsement also eliminates certain other deductions and eliminates a choice of providers. The insurance industry is highly regulated, both because it is highly complex and because, in the case of no-fault insurance, it is mandatory. It is not safe to assume that the average insured, who has no choice as a matter of law regarding whether to purchase no-fault insurance, will be able understand the full implications of choosing the PPO Endorsement, which is the point the Court of Appeals found disturbing.

Farmers also contends that the premium discount for accepting managed care under the PPO Endorsement was simply an option for those insureds who do not have health care coverage to coordinate with their no-fault insurance. This aspect of the PPO Endorsement was previously addressed above and was shown to compete, and even collide, with the legislative policy embraced in §3109a. The PPO Endorsement is inherently inconsistent with this legislative policy in that it encourages the greatest cost savings through primary coverage, which ultimately taxes the entire no-fault system. Further, the PPO Endorsement is misleading because it does not make it apparent that insureds will be giving up the supplementation of benefits that the no-fault policy offers when a health care policy is primary. If an individual does not have a health care policy, this managed-care no-fault policy provides only limited coverage for "appropriate care" and there is no policy to fill in the gaps. In short, those individuals who lack another health policy depend solely and more heavily on their no-fault policies, especially in the case of catastrophic injuries, and the PPO Endorsement does not offer them the coverage they need or which is required.

Finally, Farmers adds that the Court of Appeals should not have decided the issue because the parties did not raise it. However, the Court of Appeals merely articulated its views on this issue as a "further basis" or alternative basis for affirming. Should this Court conclude that this issue was not properly before the Court of Appeals, then it will have no effect on the Court's determination of the other issues in this case.

V. PETITIONERS HAVE STANDING TO BRING THEIR PETITION AND THE REMAINING COUNTS IN IT

A. Standing Generally

In *Lee v Macomb Co Bd of Comm'rs*, 464 Mich 726; 629 NW2d 900 (2001), this Court adopted a three-part test for determining whether a plaintiff has standing. First, the plaintiff must have suffered an injury in-fact, meaning "an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." *Id.* at 739 (internal quotation marks omitted). Second, there must be a causal connection between the injury and the defendant's conduct. *Id.* Third, "it must be likely" as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Id.* (internal quotation marks omitted). This Court affirmed the *Lee* test in *National Wildlife Federation v Cleveland Cliffs*, 471 Mich 608, 628-629; 684 NW2d 800 (2004), adding that associations "have standing to bring suit in the interest of their members where such members would have standing as individual plaintiffs." In order for an association to sue on behalf of its members, it "must allege that [its] members suffered either an actual injury or an 'imminent' injury." *Id.* at 629. Where, as in this case, the proceedings never progressed to a stage where evidence is gathered and submitted to the fact-finder, such as with a motion for summary disposition, it is enough to make "general factual allegations" regarding standing. *Id.* at 630.

MCC/MCS asks that the Court also consider the more extended discussion of standing offered by CPAN in its *amicus* brief, which they incorporate here by reference.

B. MCC/MCS Meets The Injury Test

Farmers only challenges whether MCC/MCS meets the injury prong of the *Lee* test, not the causation or remedy prongs. It contends that this lawsuit solely seeks to vindicate the interests of insureds and, because the MCC/MCS members are providers, they have not and will not suffer an injury from the PPO Endorsement. However, Farmers misrepresents the procedural posture of this case. Contrary to Farmers' representation, this case continues to concern both the count involving provider rights and the count involving the rights of insureds. In fact, in footnote 4 on page 6 of its brief, Farmers says that this "appeal only involves Counts 1 and 2," which are the claims that the PPO Endorsement violates the rights of insureds *and* providers. The only way that Farmers can propose eliminating the provider count from this case is to argue that this Court's opinion in *Advocacy Organization for Patients & Providers v. Auto Club Ins Ass'n*, 472 Mich 91; 693 NW2d 358 (2005), renders that count moot. However, this Court's plurality opinion has no binding effect under the doctrine of stare decisis. See *Robinson v City of Detroit*, 462 Mich 439, 470, n 1; 613 NW2d 307 (2000) (Corrigan, J., concurring). More importantly, the case has no bearing on standing because it was issued in 2005, after this case was already pending in this Court.

Further, the Court of Appeals' earlier opinion in *Advocacy Organization for Patients & Providers v. Auto Club Ins Ass'n*, 257 Mich App 365; 670 NW2d 569 (2003) ("*AOPP*") does not render this provider count moot. Count II alleges that the PPO Endorsement denies chiropractors the right to reimbursement for their "reasonable and customary charge" and that the PPO Endorsement forces providers "to either accept a rate less than the customary charge or be excluded completely, both of which are contrary to §3157" and case law. Petition for Review, ¶ 47 (App, p 49a). In *AOPP*, the Court of Appeals determined that a "customary" charge serves as a cap on the amount of money a provider can charge a no-fault insurer and that the no-fault insurer is obligated to reimburse a reasonable fee. *AOPP*,

supra at 376. However, the Court of Appeals also specifically refused to "delineate the permissible factors for determining what is 'reasonable'" and noted that "[i]t may be that a health-care provider's 'customary' charge is also reasonable given the services provided." *Id.* at 379. Even after *AOPP*, providers are still free to seek their customary rates when they are reasonable. In this provider count, MCC/MCS essentially contend that their customary rates are reasonable and the in-network rates that Farmers would pay all providers under this PPO Endorsement are unreasonably low or are imposed on non-network physicians. Nothing in *AOPP* requires providers to accept unreasonably low reimbursement rates. Therefore, this count remains valid and MCC/MCS have sufficiently alleged that they have suffered or will suffer imminently an economic injury from the reimbursement imposed by the PPO Endorsement. Standing may also not be rejected based on a 2005 decision, even assuming *arguendo* Farmers properly reads *AOPP*.

In attempting to separate the interests of providers and insureds under the No-Fault Act, Farmers also misconstrues their statutory relationship. Section 3105, which makes insurers liable to pay for PIP benefits, directly aligns the interests of insureds and providers. Section 3112 and *Lakeland Neurocare, supra,* inform that providers have standing to seek reimbursement "on behalf of" insureds. Insureds and providers are equally interested in enforcing the fee-for-service system established by the No-Fault Act because it guarantees that insurers will pay for a provider's reasonable fees as long as they are also customary. This reasonable reimbursement protects the interests of both insureds and providers. Providers are plainly interested in being reimbursed for their services. However, no-fault insureds are interested in requiring insurers to pay reasonable rates of reimbursement because it entices skilled providers to care for them. Without mandating reasonable reimbursement, no provider could afford to provide services to no-fault insureds. Consequently, no-fault insureds would not receive "assured"

"prompt" or "adequate" benefits. Both insureds and providers are also interested in avoiding being forced to absorb the costs of unreimbursed care.

Farmers alleges that MCC/MCS members have no particularized interest in this litigation that distinguishes them from the citizenry at-large. However, MCC and MCS expressly alleged that their members were in imminent danger of being harmed by Farmers' PPO Endorsement because it involuntarily imposed on them in-network reimbursement rates regardless of the reasonable and customary fees for their services and denied them access to the no-fault system. Regardless of their participation in PPOM for unrelated health care policies, the PPO Endorsement would have severe negative financial consequences for the chiropractors who rendered care to Farmers' no-fault insureds. Farmers concedes this injury to the MCC and MCS members in its brief on appeal, saying that MCC/MCS filed this suit "to advance the bottom lines of their members. They understand that any savings realized by insureds from selecting the Option will be paid for by care providers, including chiropractors who agree to perform services at network rates." Farmers, therefore, agrees that the members of MCC and MCS suffer a concrete and particularized economic injury from the PPO Endorsement which is not conjecture. In *National Wildlife*, the plaintiff claimed that one of its members would have to incur the cost of digging a new well because of the defendant's mining activities. *Id.* at 630. The Court used this economic injury when concluding that the plaintiff organization had standing to sue. *Id.* Therefore, this Court should acknowledge the undisputed economic injury MCC/MCS members will suffer from the PPO Endorsement.

C. The Court Should Not Expand The Standing Test In *Lee*

Farmers asks this Court to expand the *Lee* test to include the requirements that a suit be relevant to an associational plaintiff's purpose and that the suit not require the participation of individual

members of the association. The Court has already had a chance to revisit and affirm the *Lee* test recently in *National Wildlife*, and should decline further invitation.

More importantly, Farmers has adopted the habit of changing this case as it goes in an unfair attempt to prejudice MCC/MCS. Not only did it expand the record in the Court of Appeals in order to challenge standing, it now raises a legal argument for the first time that it could have raised previously. This is akin to harboring error as an "appellate parachute." See *People v Riley*, 465 Mich 442, 448; 636 NW2d 514 (2001). Farmers improperly reserved this argument as an escape route it desperately needs because of the strength of the MCC/MCS arguments that the No-Fault Act bars managed care and its PPO Endorsement. Having failed to ask either of the lower courts to define a new test for standing, it should not be allowed to do so for the first time in this Court and at this late date. If the purpose of standing is to guarantee that a plaintiff has sufficient interest in the litigation to pursue it vigorously, then MCC/MCS has already demonstrated that it has standing in pursuing this litigation in three forums. See House *Speaker v Governor*, 443 Mich 560, 572; 506 NW2d 190 (1993). There is no compelling reason to alter the standing test at this time.

Even if the Court did expand the *Lee* test to include these two factors, MCC/MCS would still have standing. First, as Farmers notes, the "organizational purpose" test is designed to ensure that a plaintiff has a vested interest in the outcome of the litigation. MCC and MCS both have a vested interest in the outcome of the litigation because they are "dedicated to promoting and protecting the public health and to establishing and protecting the rights and interests of their members, including the improvement and advancement of the practice of chiropractic in the State of Michigan." Amended Petition, ¶2 (App, p 48a). In this case, even Farmers concedes that MCC and MCS have an interest in protecting their members' right to reimbursement without the in-network restriction.

Second, the individual participation test looks at whether there is a conflict of interest among the members of an association that prevents the association from representing its members fully. Farmers evidently argues that such a conflict exists among MCC and MCS members, because some "benefit" from the PPO Endorsement by serving on PPOM provider panels. This argument is irrelevant for a number of reasons. As Kristine Dowell, Executive Director of the MCS explains, PPOM historically included only MCS – not MCC – chiropractors on its provider panels, including at the time the Commissioner approved the PPO Endorsement. PPOM contracted exclusively with MCNC and MCNC, in turn, was comprised of only MCS members. (Dowell Affidavit, Appellee's Appendix, pp. 7b-8b.) In other words, there would be no conflict within either association; if a conflict did exist it would be between the members of the two separate associations. The answer in that case would be to allow the MCC chiropractors to proceed with this litigation alone. More importantly, before the PPO Endorsement was approved, chiropractors on PPOM provider panels were not offering managed care under no-fault policies, they were offering managed care under separate health policies.

As a result, the MCS and MCC chiropractors are in the same position with respect to this PPO Endorsement. Regardless of their membership in MCC or MCS, chiropractors in both associations stand to benefit equally from a decision vindicating their right to be reimbursed at customary and reasonable rates instead of at the in-network rate if they are not on the PPOM provider panels now or in the future. Individual members would not have to join this lawsuit to ensure that the MCC and MCS are representing their interests. Not a single member of either MCS or MCC joined the Farmers program. They signed on with PPOM at a time when PPOM had not affiliated with any no-fault program. (Dowell Affidavit, Appellees' Appendix, pp 7b-8b.) What actions Farmers and PPOM undertook separately does not diminish the associations' members from challenging that the inclusion of no-fault insurance in the PPO is not lawful.

Additionally, the Court should keep in mind that to the extent Farmers is using this "benefit" argument to suggest that the individual participation test is meant to require some critical number of members of the MCC and MCS to have standing to sue, that is not supported by authority. MCC and MCS each need only one member with an injury in order to have standing to sue to vindicate their members' rights. See *National Wildlife*, *supra* at 620 (standing granted to organization on the basis of injury alleged by only three members and not imposing minimum number of members with injury). Not even the affidavit Farmers submitted from Lynne Wharton suggests that every member of the MCC and MCS have joined a PPOM provider panel and therefore at least one member in each organization will be harmed by the capped reimbursement mechanism.

Finally, if the Court concludes that the MCC *and* the MCS lack standing then it should nevertheless address the substantive question whether the No-Fault Act permits managed care and the PPO Endorsement because this issue is likely to be raised again in the future by others. See *Detroit Fire Fighters Ass'n v City of Detroit*, 449 Mich 629, 638-639; 537 NW2d 436 (1995) (addressing substantive questions in appeal despite the fact that plaintiff lacked standing because problem would arise again in future). It would be a waste of judicial resources to require other insureds and providers to go through litigation only to present this Court with the same questions.

VI. CONCLUSION

The PPO Endorsement is not a cost-savings experiment authorized by the Legislature. It is solely the creation of an insurer seeking to profit from a dramatic deviation from the structure of the No-Fault Act. The No-Fault Act delicately balances limiting the right to sue for bodily injuries sustained in automobile accidents and both providing and reimbursing all reasonably necessary services for those injuries in a fee-for-service system. But the PPO Endorsement upsets this balance and endangers the "assured, adequate, and prompt" benefits that are the heart of the no-fault scheme. *Perez v State Farm*

Mut Auto Ins Co, 418 Mich 634, 647, 344 NW2d 773 (1983). MCC/MCS respectfully ask that this Court hold that PPO Endorsement violates the No-Fault Act by imposing impermissible managed care on PIP benefits and, therefore, the Commissioner's decision to approve the PPO Endorsement and deny a contested case hearing was not authorized by law.

Respectfully submitted,

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